Perceptions of Mental Health Services

2004 Adult Consumer Survey

Perceptions of Adult Consumers Of Publicly Funded Mental Health Services in Montana

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Montana Adult Consumer Satisfaction Project

Fiscal Year 2004 Report

Introduction

The Mental Health Services Bureau (MHSB) of the Addictive and Mental Disorders Division (AMDD) conducts the Montana Consumer Satisfaction Project. Funding support is provided by the Data Infrastructure Grant from the Substance Abuse and Mental Health Services Administration. MHSB administers a survey to Montana mental health service consumers annually, with the goal of eliciting consumer opinions regarding the overall quality of Montana's mental health care system. This report details the statewide results of the FY2004 Montana Adult Consumer Satisfaction Survey, administered in October 2004. The report reflects survey results from only outpatient adult consumers who have received case management services at any time during FY2004.

Adult Survey Quick Facts

- Participating providers: 5
- Surveys collected: 410
- Average age: 47
- Gender: 64% female, 36% male
- Average time in services: 6 years

Scale Scores (0-1)

- Access to Services: .81
- Appropriateness/Quality of Services: .73
- Satisfaction with Services: .83
- Effectiveness/Outcomes of Services: .61

Survey Methods

Instrument. Montana's survey instrument is the national 28-item Mental Health Statistics Improvement Program (MHSIP) Satisfaction Survey. The survey has been nationally standardized and is required of all states as part of an annual data report submitted to the National Center for Mental Health Services. Montana's survey results can, therefore, be compared with those of other similar states, who have used similar target populations, and similar methods of administration. Demographic and descriptive items gather information on gender and ethnicity, the type of services a participant is receiving, and the length of time a participant has been receiving services. The instrument also contains a section where participants can comment either on specific survey items or about their general perceptions of the programs where they receive services.

Administration. This year the surveys were distributed directly to recipients by mail. Each envelope contained a cover letter that explained the goal of the survey and the importance of consumer input, a three-page survey, a self-addressed stamped envelope, and an entry form for a lottery to win a $50 gift

certificate to his/her local grocery store. To maintain confidentiality, the return address used for the Addictive and Mental Disorders Division was the name of the Quality Assurance Manager and the Division's post office mailing address. The cover letter also contained a toll-free telephone number to call if respondents had any questions, comments, or concerns regarding the survey. This was the first year that entry forms for a lottery were included in the mailing. A considerable number of survey recipients called the toll-free number with questions, and were enthusiastic about entering the drawing. We believe this incentive benefited the Division by increasing the response rate, and benefited two consumers in the state, who received their gift certificates at Thanksgiving, and at Christmas.

WHY THIS SURVEY IS DIFFERENT FROM THE 2003 SURVEY

The Montana consumer survey sample contained consumers aged 18 and older, who were randomly selected from a list of all adults receiving case management services any time during SFY2004. There were two major differences in this past year's sample from that of 2003. First, we changed our distribution method from point of contact (mental health centers hand out surveys to consumers coming in for services) to a mail-out survey. The mail method is well known in survey research to produce responses that are less positive than other methods, presumably because it eliminates the tendency for respondents to want to look favorable in front of others. Second, we selected our sample from a list of consumers who had received case management at some time during the previous year. As discussed in the Survey Results section, there were 9 items with significantly lower scores than the 2003 results. For the next survey, planned for the summer of 2005, we will follow the same protocol as the 2004 survey, which should provide a better basis for comparison. This report provides comparative statistics across 2003 and 2004. However, any conclusions that may be drawn would be premature, without a new, similar sample.

Completion Rate. There were 1,615 surveys mailed out and 417 returned, resulting in an overall return rate of 25%. Of the 1,615 surveys sent out, 219 were initially returned undeliverable, due to incorrect or outdated addresses. Our staff were able to locate new addresses for 139, resulting in 80 surveys (5%) that were declared undeliverable. Some surveys were eliminated from analysis because they were incomplete. The final sample size was 410 surveys, placing it within the 95% confidence level, with an interval of +/-5. This means, for example, that if 47% of the sample answered yes to a question, we can be sure that if the entire mental health service population had been asked, between 42% and 52% would have answered similarly.

Validity of the Data. To ensure scale validity, each scale analysis included only those surveys in which at least 75% of the scale items had been answered (and for one scale of 3 items, 66%). Regarding generalizability to rural populations, 52 surveys (13% of the sample) were received from clients living in rural counties.

Analysis

Information gathered from Consumer Satisfaction Surveys is analyzed on a statewide level. In addition, providers receive a summarized report of consumers of their services that can be compared to the state average. *This* report contains only the statewide results. Some of the analyses use the scale scores and others use the responses to individual items.

The analysis measures satisfaction in four domains, or scales. These scales – *Access* to services, *Quality/Appropriateness* of services, self-assessed *Effectiveness/Outcomes*, and overall *Satisfaction* - are common to all U.S. states that administer the MHSIP Survey.

1. Access: Entry into mental health services is quick, easy, and convenient
2. Appropriateness/Quality: Services are individualized to address a consumer's strengths and weaknesses, cultural context, preference, and recovery goals.
3. Effectiveness/Outcomes: The extent to which services provided to individuals with emotional and behavior disorders have a positive or negative effect on their well-being, life circumstances, and capacity for self-management and recovery.
4. Satisfaction: Overall satisfaction with services provided.

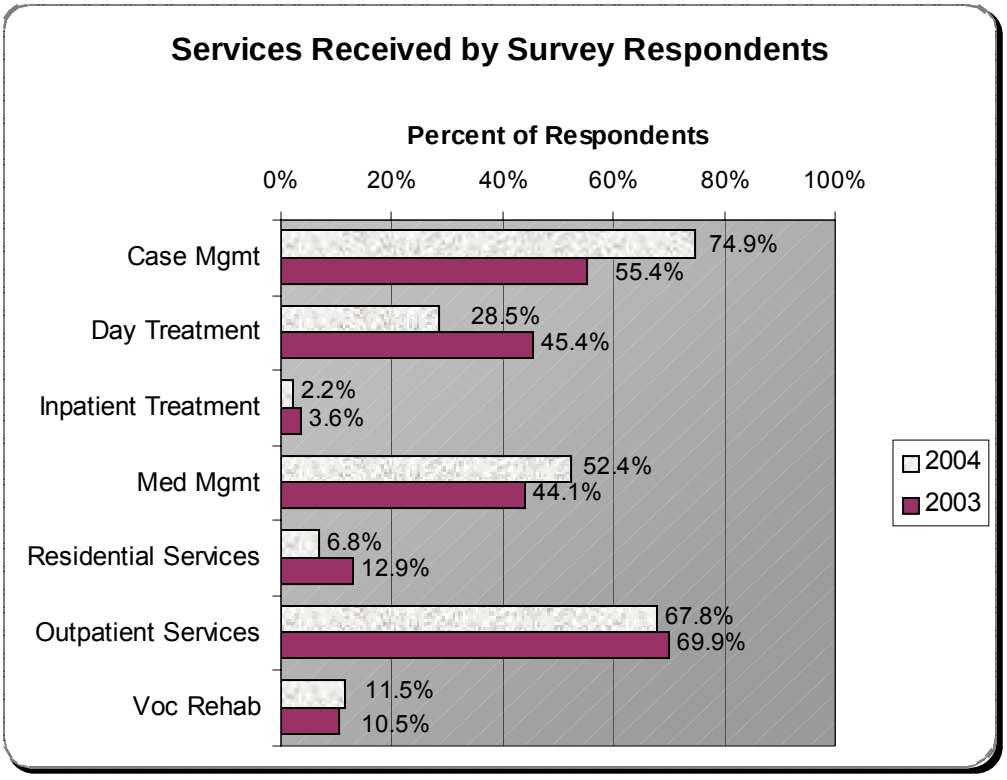
How to Understand the Scores

For each item of each scale, the frequency of responses was calculated. The most noteworthy statistic for each item is the cumulative percent of "Strongly Agree" and "Agree", indicating the proportion of people responding positively to the item. For each of the 4 scales, the "proportion positives" for all scale items were averaged to provide the overall score for the scale, which varies in value from 0 to 1. For example, a score of .89 indicates that 89% of the sample either strongly agreed, or agreed with the statement.

Survey Results

Demographics -
A total of 410 adult surveys were returned complete enough for analysis. This is 2.9% of all Montana adult public mental health care recipients, within the 95% confidence level in a power analysis. Female respondents numbered 263 (64% of the sample). This number represents 2.7% of Montana women who received a public mental health service in FY2004. Men numbered 147, representing 3.1% of all Montana men who received services last year. Ages ranged from 18 to 78 years old, with an average age of 47, four years older than the average age in the 2003 sample. Ninety-one percent of the sample was Caucasian, and 9% was Native American. Thirteen (3.3%) reported being of Hispanic ethnicity. Fifty-two (13%) respondents reported living in a rural community. Forty-seven (12% of the sample) were funded by the State Mental Health Services Plan. The other 363 respondents had Medicaid. The average time these individuals had been in public mental health services was 6 years.

Services Received –
The chart below shows the percentage of respondents receiving various services at the time of the survey. Note that the sample was selected based on respondents having received case management services *at any time during the past year*. Twenty-five percent of the sample was not receiving case management at the time of the survey.



Services provided by:

Provider	2004 Survey Respondents	2003 Survey Respondents
AWARE, Inc	6	15
EMCMHC	30	85
GTCMHC	24	211
SCMRMHC	79	134
WMMHC	268	135

Scale Scores –
The chart below shows the average score for each scale for 2003 and 2004.

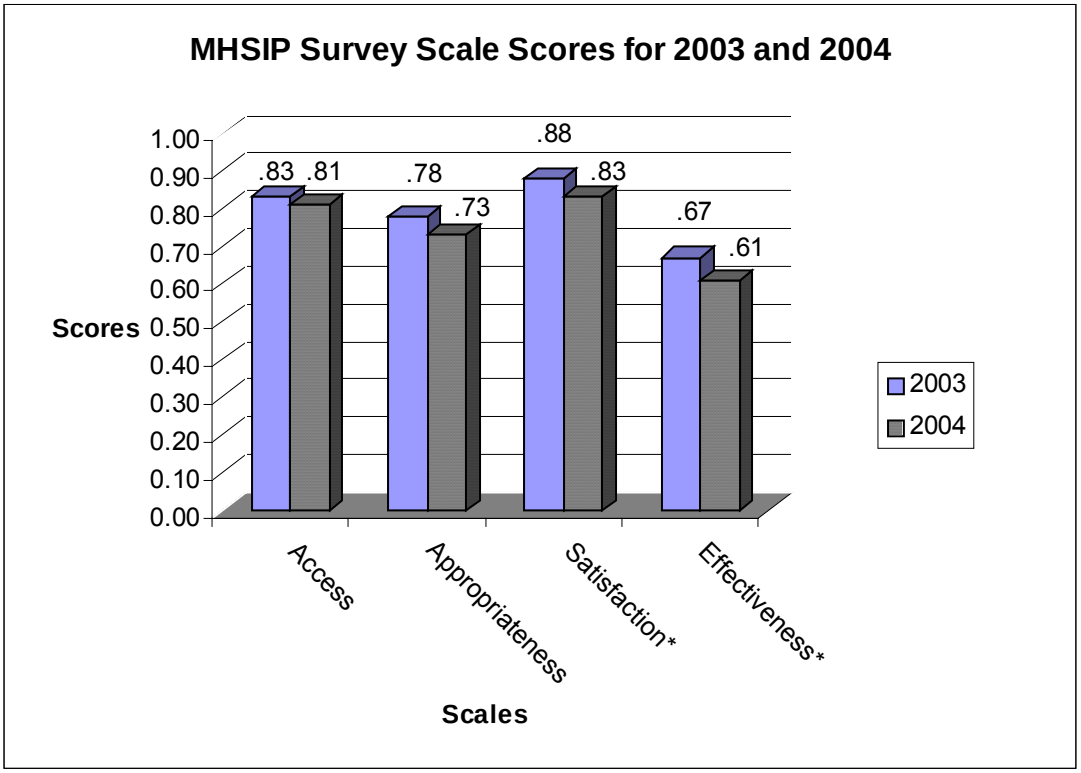


Table 1. Comparison of MHSIP Scale Scores for 2003 and 2004

	Access	Appropriateness	Satisfaction*	Effectiveness*
2003	.83	.78	.88	.67
2004	.81	.73	.83	.61

The scale scores of *Satisfaction* and *Effectiveness* for 2004 were significantly lower than those for 2003. More specifically, 9 of the individual items scattered across all the scales varied significantly between the two years. In all cases they were lower in 2004. Since the sampling and distribution methodologies are different for the two years, these differences cannot be satisfactorily explained.

Survey Questions Showing Significant Change Over the Past Two Years	2003	2004	P Value
Q2 - If I had other choices, I would still get services from this agency.	0.86	0.78	p ≤ .01
Q5 - Staff were willing to see me as often as I felt it was necessary	0.86	0.81	p ≤ .01
Q8 - I was able to get all the services I thought I needed.	0.86	0.79	p ≤ .05
Q10 - Staff here believe that I can grow, change and recover.	0.83	0.71	p ≤ .01
Q13 - I felt free to complain.	0.74	0.68	p ≤ .05
Q18 - Staff were sensitive to my cultural background (race, religion, language, etc.).	0.75	0.68	p ≤ .05
Q19 - Staff helped me obtain the information I needed so that I could take charge of managing my illness.	0.82	0.72	p ≤ .05
Q25 - I do better in social situations.	0.66	0.57	p ≤ .01
Q26 - I do better in school and/or work.	0.45	0.31	p ≤ .01

Highest and Lowest Scores for 2004 and 2003

Top Five Responses. Tables 2 and 3 show the five items receiving the highest proportion of positive responses for 2004 and 2003.

Table 2. High scores from 2004

Top Five – Highest Positively Ranked Items		
Rank (Not Item #)	**Survey Item**	**Score**
#1	Services were available at times that were good for me.	.89
#2	I like the services I received here.	.87
#3	I was given information about my rights.	.85
#4	Staff respected my wishes about who is and who is not to be given information about my treatment.	.85
#5	I would recommend this agency to a friend or family member.	.84

The highest-ranking items come from the Access, Quality/Appropriateness, and Satisfaction scales. This general satisfaction with staff and services is mirrored in participants' comments, which often single out a particular staff member as helpful. The highest-ranking item, "Services were available at times that were good for me," was endorsed significantly more often by men (91%) then by women (87%).

Table 3. High scores from 2003

Top Five – Highest Positively Ranked Items		
Rank (Not Item #)	**Survey Item**	**Score**
#1	I like the services that I received here.	.91
#2	Services were available at times that were good for me.	.90
#3	I would recommend this agency to a friend or family member.	.88
#4	I was given information about my rights.	.87
#5	Staff respected my wishes about who is and who is not to be given information about my treatment.	.87

Tables 4 and 5 show the lowest-ranking scores for 2004 and 2003.

Table 4. Low scores from 2004

Bottom Five – Lowest Positively Ranked Items		
Rank (Not Item #)	**Survey Item**	**Score**
#28	I do better in school and/or work.	.31
#27	My symptoms don't bother me as much as they use to.	.57
#26	I do better in social situations.	.57
#25	I am getting along better with my family.	.63
#24	My housing situation has improved.	.63

All of the items in Table 4 are from the Effectiveness/Outcomes Scale. This scale is typically the lowest scoring scale on the survey, nationally as well as in Montana. Item 28, "I do better in school and/or work", was unusually low in the 2004 survey. This is partially due to the fact that 39% of respondents selected "does not apply" for their answer, a significant increase over the previous year's 8%. School and employment are considered to be productive and meaningful activities, and thus, important treatment outcome measures. It is not clear whether those who answered "does not apply" had good reason to believe that school and work were not appropriate for them, or whether they simply believed it would not be possible for them. The latter may speak to consumers' beliefs in their ability to recover. The reported dissatisfaction with school and/or work performance did not differ by gender this past year. The fifth least popular item, "My housing situation has improved," was less popular with women than with men. Women were significantly less likely to agree with the statement. There were no gender differences in any other survey items.

Table 5. Low scores from 2003

Bottom Five – Lowest Positively Ranked Items		
Rank (Not Item #)	**Survey Item**	**Score**
#28	I do better in school and/or work.	.45
#27	My housing situation has improved.	.63
#26	I do better in social situations.	.66
#25	My symptoms don't bother me as much as they use to.	.66
#24	I, not staff, decided my treatment goals.	.66

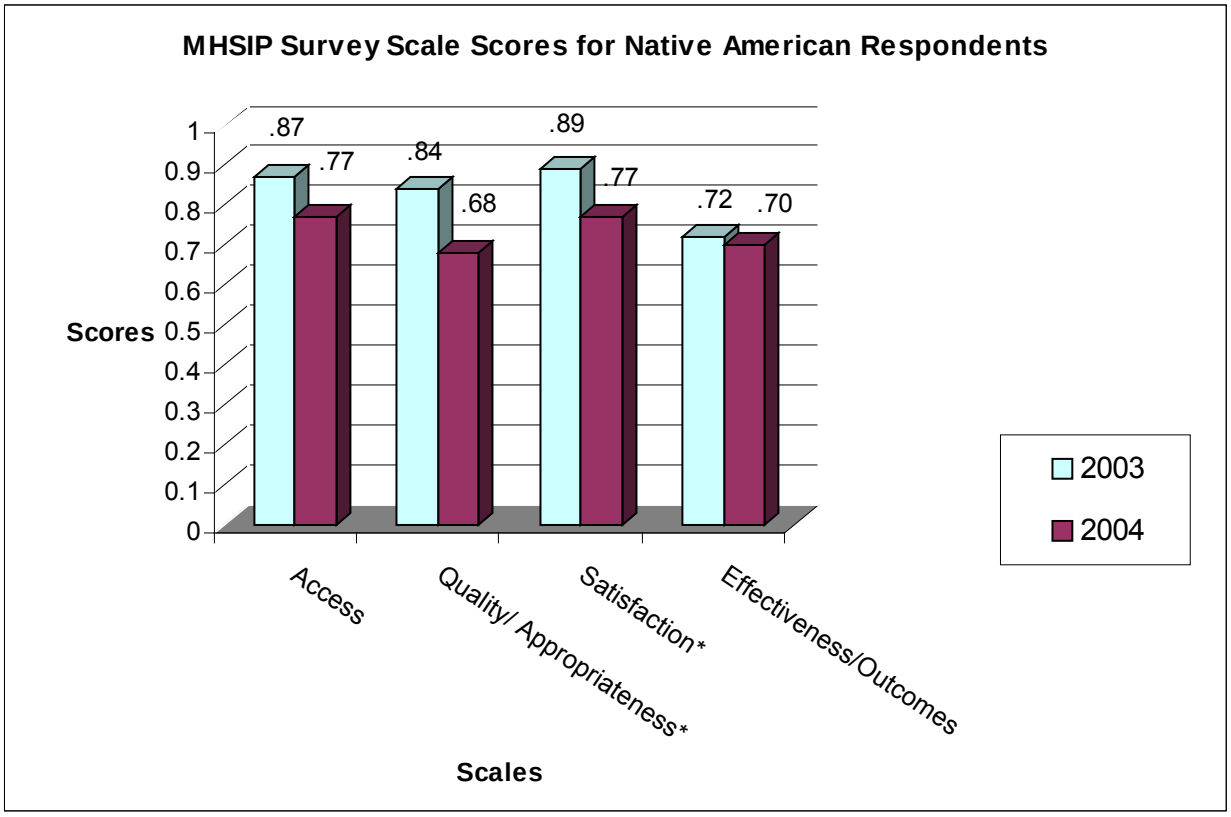
Similar to the 2004 scores in Table 4, the majority of the Table 5 2003 scores are from the Effectiveness/Outcomes scale. For both years, these lower scores suggest that mental health care recipients have an appreciation for the quality and availability of services they receive, but continue to struggle in achieving positive change in their lives. However, in 2003 the item ranked at the bottom ("I do better in school and/or work") showed the most contrast between the sexes - .40 for women and .50 for men. Women perceived themselves as functioning less well in this area than did men. This gender difference did not carry over to the 2004 survey results.

Native American Representation

Thirty-six adult Native Americans completed the MHSIP survey (2.5% of 1,437 served in SFY2004). This contrasts with last year's numbers as follows – Fifty-five Native American respondents were included in the 2003 survey analysis (4% of 1,345 served in SFY2003). Due to the smaller population of Native American mental health care consumers, a sample of over 300 would be required to reach the 95% confidence level. However, smaller sample sizes yield valid and useful information.

Of the 36 respondents in 2004, 13 were male and 23 were female. These numbers represent 2.2% of Native American female adults served, and 3.2% of adult males. For men, ages ranged from 18 to 56 years old, with an average age of 42. Women's ages ranged from 21 to 67, with an average age of 47. When asked about their tribal affiliations, 28 consumers identified tribal affiliations representing 12 tribes.

Scale Scores. The chart below shows the overall score for each scale.



The 2004 scales Appropriateness/Quality and Satisfaction were significantly lower than those for 2003 for the Native American sample.

Table 6. Comparison of Native American Scores with those of non-Native Americans- **2004**

Sample	Access	Appropriateness	Satisfaction	Effectiveness
Native American Respondents	.77	.68	.77	.70
Non-Native American Respondents	.81	.74	.84	.60

Although the differences in the scale scores shown above appear to be different, *they did not reach statistical significance*, due to the differences in the sample sizes and variability of responses.

Table 7. Individual items with significant change from **2003 to 2004**

Survey Questions	2003	2004	P Value
Q1 - I like the services that I received here.	0.94	0.81	p ≤ .05
Q2 - If I had other choices, I would still get services from this agency.	0.86	0.72	p ≤ .01
Q7 - Services were available at times that were good for me.	0.96	0.81	p ≤ .05
Q8 - I was able to get all the services I thought I needed.	0.92	0.67	p ≤ .01
Q10 - Staff here believe that I can grow, change and recover.	0.94	0.72	p ≤ .05
Q17 - I, not staff, decided my treatment goals.	0.79	0.54	p ≤ .01

Top and Bottom Five Responses by Native Americans - 2004

Top Five. Table 8 shows the five items receiving the *highest* proportion of positive responses by Native American service recipients. The highest-ranking items address every scale, indicating a high level of satisfaction with at least some aspect of access, appropriateness/quality, satisfaction, and effectiveness/outcomes. Two items tied for third and fifth place. One of the top three items, "My housing situation has improved," was ranked in 2003 next to the bottom, indicating that either the Native American consumers experienced an improvement in housing during 2004, or this particular sample of Native Americans had a different experience with housing. Ranking 25th in 2003, "I saw my psychiatrist as often as I needed to," moved up in 2004 to fifth place.

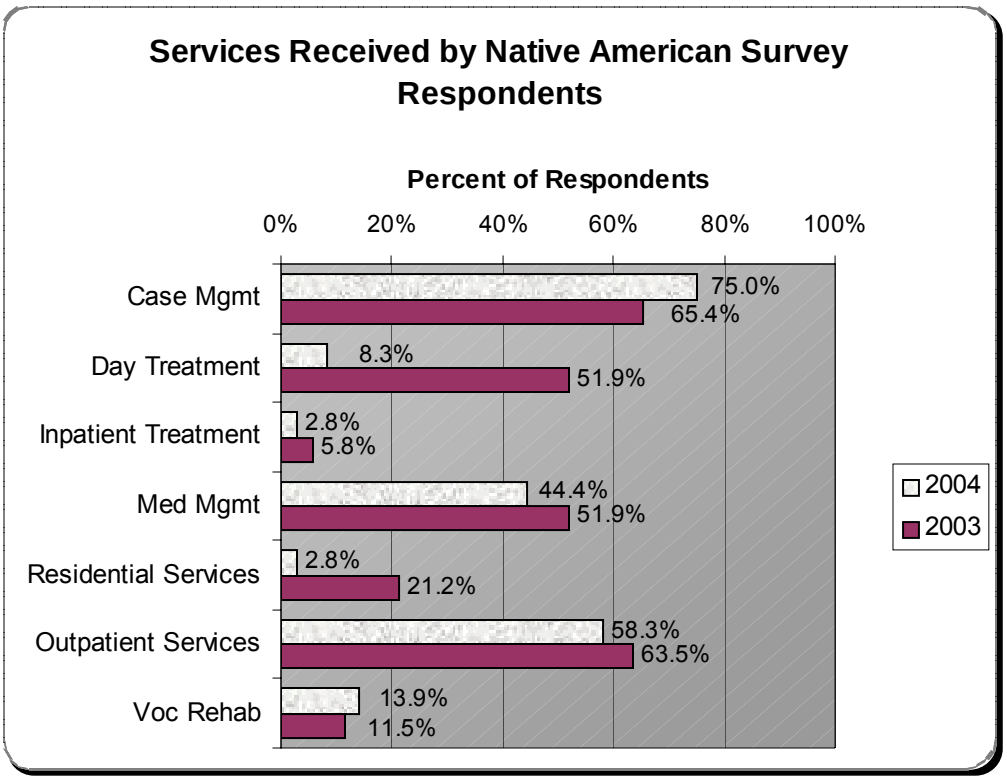
Table 8.

***Top Five* – Highest Positively Ranked Items By Native American Service Recipients-2004**		
Rank **(Not Item #)**	**Survey Item**	**Score**
#1	I felt comfortable asking questions about my treatment and medication.	.86
#2	I deal more effectively with daily problems.	.86
#3	The location of services was convenient (parking, public transportation, distance, etc.)	.83
#3	My housing situation has improved.	.83
#4	I like the services that I received here.	.81
#5	I saw my psychiatrist as often as I needed to.	.78
#5	Staff respected my wishes about who is and who is not to be given information about my treatment.	.78

Table 9 below shows the lowest ranked survey items by Native Americans for 2004.

Table 9.

***Bottom Five* – Lowest Positively Ranked Items By Native American Service Recipients - 2004**		
Rank **(Not Item #)**	**Survey Item**	**Score**
#28	I do better in school and/or work.	.45
#27	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	.51
#26	I, not staff, decided my treatment goals.	.54
#25	I felt free to complain.	.60
#24	Staff told me what medication side effects to watch out for.	.61
#24	My symptoms don't bother me as much as they used to.	.61



Services provided by:

Provider	2004 Survey Respondents	2003 Survey Respondents
AWARE, Inc	3	4
EMCMHC	2	2
GTCMHC	5	23
SCMRMHC	6	9
WMMHC	20	14

Summary

Five major mental health providers participated in the MHSIP Consumer Satisfaction Survey project. A total of 410 surveys were returned. Analysis of the surveys revealed that, overall, Montana mental health care recipients are satisfied with access to services, and the quality and appropriateness of those services.

The 2004 survey was the first year that a mail-out method of distribution was used. The return rate was encouraging for this method, although further efforts must be made to adequately sample Native American service consumers. An additional confounding factor between the two samples is that the 2003 sample was drawn from all adult consumers, and the 2004 sample was drawn from only those consumers who had received targeted case management at some time during the previous year. The

differences in responses between 2003 and 2004 are interesting; however, no valid explanation can be drawn until a future mail-out sample of individuals receiving targeted case management is completed for a more appropriate comparison.

Consumers reported that they are less satisfied with their progress toward recovery than with the overall quality and access to services – a finding shared by consumers in other states. The severity of illness that our mental health clients experience means that treatment will be difficult, and improvement will often occur in small increments. Our mental health care system must continue to strive toward state-of-the-art treatment models, and a philosophy that encourages and supports recovery for our citizens with serious mental illness.

Comments from Survey Respondents

◊ "The health counselors do the best they can, I only wish they had more time."

◊ "I drove 26 miles to Anaconda to see a counselor, who listened to my needs, helped me create a treatment plan, and helped me reach my goals. The counselor helped me a lot to overcome some of my problems."

◊ "I'd like to see a 24/7 year-round safe house for us to go to when times are rough at home."

◊ "I would like additional help with budgeting, managing money, and learning work skills."

◊ "Case managers really help a lot. We need more case management services available."

◊ "One major need I see is community outreach to individuals not quite yet in a crisis. Someone with mental health experience to meet and explain services available to them before an ER visit is needed"

◊ "I received excellent help from my case manager. However, a few months ago he quit in order to take another job. I have been told that mental health centers lose their best people because the pay is too low."

◊ "I couldn't stay in my home without my counselor and Medicaid help."

◊ "One time I was homeless and my case manager found me an apartment with rent. Right on!!"

◊ "The woman who cooks for us is wonderful. I've never had a bad meal there."

◊ "I have been involved in local mental health for many years. I have learned to take care of myself. I can handle crisis situations I find myself in. I wouldn't be alive without [the mental health counselors]."

◊ "Services were cut back so I cannot see my therapist as often as I wish. Although my therapist and I feel I can learn and change, I know it will take a long time to recover."

◊ “My case manager dictates what supports I need without any consultation with me. [He/she] fills out my annual treatment plan and my only contribution is to sign the form. But, overall, I am getting better.”

◊ “The PACT team has been very supportive and when I’m in a crisis they are there for me.”

◊ “I would not be alive today without _____ and _____ - they are Great!”